

# Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935  
Madison, WI 53708-8935

FAX #: (608) 261-7083  
Phone #: (608) 266-2112

1400 E. Washington Avenue  
Madison, WI 53703

E-Mail: [web@drl.state.wi.us](mailto:web@drl.state.wi.us)  
Website: <http://www.drl.state.wi.us>

## APPLICATION INFORMATION FORM

### ATTENTION

### IMPORTANT INFORMATION PLEASE READ

Enclosed is the application packet you recently requested from the Wisconsin Department of Regulation and Licensing.

To avoid any unnecessary errors, take a moment to review the entire application packet before you begin to complete your application.

We will mail you a check sheet within 10-15 working days after receipt of your application in this office. The check sheet will include an identification number that allows you to check the status of your application by calling the **Interactive Voice Response System, (608) 261-7925**. The Interactive Voice Response System will inform you of any requirements not met. You may also check the status of your application on our web-site: <http://www.drl.state.wi.us>. Look under "Applicant Services."

It is your obligation as an applicant to see that the items listed as "Is Required" are forwarded to the Department of Regulation and Licensing. The Department will not contact other agencies or jurisdictions for information/documents to complete your application. We will update check sheets within 3-5 working days of receipt of documents. An application is not considered complete until we receive all the required documents and fees.

Once your application is complete, check the department's web-site: <http://www.drl.state.wi.us>. Look under "Business/Professional License Lookup" for your official credential number and grant date.

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## PROFESSIONAL COUNSELOR TRAINING CERTIFICATE APPLICATION INFORMATION

### MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING, AND SOCIAL WORK EXAMINING BOARD

The Wisconsin Statutes provide that the Professional Counselor Section will grant a Professional Counselor Training Certificate to any applicant who has the required education and submits evidence satisfactory to the Professional Counselor Section that he or she is employed full-time, or has an offer of full-time employment, as a professional counselor in a supervised clinical professional counseling practice or in a position in which the applicant will, in the opinion of the Professional Counselor Section, receive training and supervision equivalent to the training and supervision received in a full-time supervised clinical professional counseling practice.

The training certificate is valid for 2 years, and may not be renewed.

Application is not complete until all of the following documents have been received:

- \$10.00 application fee
- Application
- Addendum to Application (Social Security Number)
- Convictions and Pending Charges (Form #2252) if applicable
- Verification of Credential if credentialed in other states or territories active or inactive status (Form #2572)
- Certificate of Professional Education (Form #1960)
- If your degree is not in professional counseling or one of the degrees listed at the top of Page 2 of 5 of the application, the following are also required:
  1. Curriculum requirements (Form #2239)
  2. Official transcript showing master's or doctorate degree
  3. Course descriptions
- Employer Affidavit (Form #2456)

To satisfy the supervision requirement, an employer must complete the affidavit to verify that the applicant will be receiving acceptable supervision by a qualified supervisor as specified in SFC 10.01(6):

"Supervision" means the direction of professional counseling practice in face-to-face individual or group sessions lasting at least one hour between the person whose practice is being supervised and the person who is providing the supervision of the practice, during each week that the person seeking certification practices professional counseling; such supervision may be exercised by a person other than an employment supervisor. The supervisor may exercise discretion as to the frequency, duration, and intensity of the supervision sessions to meet an average of one hour supervised session per week during the supervision period.

A supervisor may not permit a supervisee to engage in any professional counseling practice that the supervisor cannot competently perform. All supervisors shall be legally and ethically responsible for the supervised activities of the professional counselor supervisee. Supervisors shall be available or make appropriate provision for an emergency consultation and intervention. Supervisors shall be able to interrupt or stop the supervisee from practicing in given cases, or recommend to the supervisee's employer that the employer interrupt or stop the supervisee from practicing in given cases, and to terminate the supervised relationship if necessary.

# **State of Wisconsin Department of Regulation & Licensing**

Supervision may be exercised by:

- (1) An applicant who has received a master's degree shall complete at least 3,000 hours of professional counseling practice in no less than 2 years, including at least 1,000 hours of face-to-face client contact, under the supervision of a person specified in s. SFC 12.02(2) before the applicant is eligible for a license as a professional counselor.
- (2) An applicant who has received a doctoral degree shall complete, either during or after completion of the doctoral degree program, at least 1,000 hours of professional counseling practice, under the supervision of a person specified in s. SFC 12.02(2) before the applicant is eligible for a license as a professional counselor.

## **RECORD RETENTION:**

Applications and supporting documents for licensure, answer sheets, examination products and examiner evaluation documents for the jurisprudence examination are retained one year after the examination date. Booklets used by candidates are retained two months after release of grades. Records of specific examination content (jurisprudence examination file copies) are retained for five years.

**\*\*** The training certificate is valid for 2 years. If you do not contact us by that time we will consider your application abandoned, and your file will be destroyed. You must reapply as a new applicant if you wish to pursue it in the future.

## **MAILING ADDRESS:**

Professional Counselor Section  
Wisconsin Department of Regulation and Licensing  
P.O. Box 8935  
Madison, WI 53708-8935

## **EXPRESS DELIVERY:**

Professional Counselor Section  
Wisconsin Department of Regulation and Licensing  
1400 E. Washington Ave.  
Madison, WI 53703

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## PROFESSIONAL COUNSELOR TRAINING CERTIFICATE APPLICATION

### MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING, AND SOCIAL WORK EXAMINING BOARD

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

If you wish to receive a training certificate for use during your supervised practice, you may complete this application for a regular Professional Counselor Training Certificate. NOTE: If you want a training certificate, DO NOT fill out the regular Professional Counselor application.

☐ Your name and address are available to the public.  
Check box if you wish your name & address withheld from lists of 10 or more credential holders (sec. 440.14, Stats.).

PLEASE TYPE OR PRINT IN INK

Last Name	First Name	MI	Former / Maiden Name(s)
-----------	------------	----	-------------------------

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth ____ month ____ day ____ year	Daytime Telephone Number (____) _____ - _____
--	--

Ethnic/gender status information is optional.	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Ethnic: <input type="checkbox"/> White, not of Hispanic origin	<input type="checkbox"/> American Indian or Alaskan
		<input type="checkbox"/> Black, not of Hispanic origin	<input type="checkbox"/> Asian or Pacific Islander
		<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other

### PROFESSIONAL EDUCATION (schools, locations, degrees and date of graduation)

SCHOOL	LOCATION	DEGREE	DATE OF GRADUATION (M/D/Y)

### APPLICATION FEE:

(Make check payable to:  
Department of Regulation and Licensing and  
attach to application.)

\_\_\_\_\_ \$10.00 Professional Counselor Training Certificate

For Receipting Use Only

# State of Wisconsin Department of Regulation & Licensing

**If you do not hold a master's or doctoral degree in professional counseling or one of the majors listed below, you must complete the enclosed form #2239 which explains the curriculum requirements for master's or doctoral degree equivalency. Official transcripts and course descriptions are also required.**

Guidance and Counseling	Counseling Psychology
Rehabilitation Counseling	Vocational Rehabilitation Counseling
Vocational Rehabilitation	Guidance-Vocational Counseling
Educational Rehabilitation Counseling	Educational Counseling
Rehabilitation Psychology	Vocational Rehabilitation Guidance
Counselor Education	M.S. in Ed. - emphasis in Counseling or Guidance
Behavioral Disabilities	M.S. in Ed. - emphasis in Guidance & Counseling
Educational Psychology - Counseling	M.S. in Ed. - emphasis in Community Counseling
Community Human Services - Counseling emphasis - from UW Green Bay, LaCrosse or Oshkosh	

**Mark an "X" in the appropriate box.** If you answer YES to any question, give an explanation of all details on an attached sheet. *Please print your name and birth date at the top of each attached sheet.* A "YES" response does not necessarily preclude licensure.

	<u>YES</u>	<u>NO</u>
a. Do you hold, or have you ever held a credential (license, certification or registration) as a professional counselor in any other government jurisdiction? <b>If yes, list where; and submit the enclosed Verification Form (Form #1971) to each jurisdiction.</b>	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you hold, or have you ever held a credential (license, certification or registration) in any other occupation or profession in Wisconsin or any other jurisdiction? <b>If yes, what credential(s) in which jurisdiction(s)?</b>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you ever applied for and been denied a credential (license, certification or registration) in any profession? <b>If yes, give details on an attached sheet, including the name of the profession and the licensing authority.</b>	<input type="checkbox"/>	<input type="checkbox"/>
d. Has your credential (license, certification, registration) in any profession ever been restricted, revoked, suspended, limited, surrendered or canceled, or has any other disciplinary action been taken against it in Wisconsin or any other jurisdiction? <b>If yes, give details on an attached sheet, including the name of the profession and the authority.</b>	<input type="checkbox"/>	<input type="checkbox"/>
e. Have you ever surrendered or canceled your credential (license, certification or registration) in lieu of disciplinary proceedings by the issuing authority in any profession in Wisconsin or any other jurisdiction? <b>If yes, give details on an attached sheet, including the name of the profession and the authority.</b>	<input type="checkbox"/>	<input type="checkbox"/>
f. Is disciplinary action pending against you in any jurisdiction? <b>If yes, give details on an attached sheet, including the name of the profession and the authority.</b>	<input type="checkbox"/>	<input type="checkbox"/>
g. Have you ever been the subject of a disciplinary action by a regulatory committee of a professional association? If yes, give details on an attached sheet, including the name of the association.	<input type="checkbox"/>	<input type="checkbox"/>
h. Have you ever been convicted of a misdemeanor or felony? If yes, attach copies of all formal pleadings and all documents relevant to the ultimate resolution of the matter.	<input type="checkbox"/>	<input type="checkbox"/>
i. Do you have any felony or misdemeanor charges pending against you? If yes, give details and identify court on attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
j. Have you ever been the defendant in a malpractice suit, and either entered into a settlement agreement or paid court-awarded damages, or is there such a suit pending? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>
k. Have you ever been involuntarily terminated from any behavioral health or related employment for unprofessional conduct? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>

# State of Wisconsin Department of Regulation & Licensing

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## **AFFIDAVIT OF APPLICANT** **(sign and date in the presence of a notary)**

I state that I am the person referred to on this application and that all of the answers set forth are each and all strictly true in every respect. I understand that false or forged statements made in connection with this application may be grounds for revocation of my license. I also understand that if I am issued a license, failure to comply with the laws or rules of either the Marriage and Family Therapy, Professional Counseling, and Social Work Examining Board or the Wisconsin Department of Regulation and Licensing will be cause for disciplinary action.

\_\_\_\_\_  
Signature of Applicant

State of \_\_\_\_\_ County of \_\_\_\_\_

Subscribed and sworn to before this \_\_\_\_\_ day of

\_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_  
(Applicant name)

\_\_\_\_\_  
Signature of Notary Public

**S E A L**

\_\_\_\_\_  
Date Commission Expires

**NOTE: THIS AFFIDAVIT MUST BE SIGNED BY THE APPLICANT BEFORE THE NOTARY ON THE SAME DATE.**

# State of Wisconsin Department of Regulation & Licensing

## ADDENDUM TO APPLICATION

**SOCIAL SECURITY NUMBER.** Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.<sup>1</sup> A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

\_\_\_\_\_  
First Name Middle Initial Last Name

\_\_\_\_\_  
Profession

Date of Birth    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_  
                                 month                   day                   year

-  -

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Workforce Development for purposes of administering the child and spousal support program,<sup>2</sup> to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,<sup>3</sup> and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.<sup>4</sup>

<sup>1</sup> Section 440.03 (11m), Wis. Stats.

<sup>2</sup> Sections 49.22, and 440.13, Wis. Stats.

<sup>3</sup> Section 440.12, Wis. Stats.

<sup>4</sup> Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.

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## CONVICTIONS AND PENDING CHARGES

If you have been convicted of a crime or have criminal charges pending against you, complete this form and return it with your application. Include a \$6.00 Crime Information Bureau report fee in addition to your original application fees.

The Fair Employment Act (sections 111.31-111.395, Wis. Stats.) prohibits employment discrimination on the basis of conviction record or arrest record unless the circumstances of the conviction or arrest substantially relate to the circumstances of the particular job or licensed activity. The information requested on this form will be used to determine whether your application should be granted, approved with limitations, or denied. The information you provide on this form may be verified against criminal information records. Omission of information on this form will be considered a false statement on an application.

Profession you are applying for: \_\_\_\_\_

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip) \_\_\_\_\_

Mail To Address (if different) \_\_\_\_\_

Date of Birth _____ month      day      year	Social Security Number _____ Information helps us identify your record, but is voluntary. It is not available to the public.
--	--

Ethnic/gender information is required to check criminal information records. Sex: ☐ M ☐ F Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

1. List all other names used: \_\_\_\_\_
2. List all felonies, misdemeanors, and other violations of state or federal law of which you have ever been convicted, in this state or any other, whether the conviction resulted from a plea of no contest or a guilty plea or verdict. For each, list the date and location of the conviction. Please include all convictions that involved alcohol or other drug use, including convictions for operating while intoxicated. Do not include municipal ordinance violations or other traffic offenses.

**It is your responsibility to submit certified copies of the police report or criminal complaint, judgment of conviction and sentencing, and verification of your compliance with all terms of each sentence, including chemical dependency assessments if ordered by the court. If the conviction is old and records have been destroyed, you must submit a written description of each offense, along with an explanation of the penalties imposed and verification that you completed all requirements.**

<u>OFFENSE</u>	<u>DATE</u>	<u>CITY/STATE</u>

Attach additional sheet(s) if necessary.

# State of Wisconsin Department of Regulation & Licensing

3. Have you ever been sentenced by a court to participate in an alcohol or other drug assessment, treatment or counseling program? YES NO MO/YR COMPLETED  
☐ ☐ \_\_\_\_\_  
Did you successfully complete the program? ☐ ☐ \_\_\_\_\_  
Please attach the certificate of completion/discharge summary.

- (Check all that apply)
4. Have you ever been sentenced to: YES NO MO/YR COMPLETED  
☐ Probation ☐ ☐ \_\_\_\_\_  
☐ Parole ☐ ☐ \_\_\_\_\_  
☐ Ordered to pay restitution ☐ ☐ \_\_\_\_\_  
Did you successfully complete one of the above as ordered by the court? ☐ ☐ \_\_\_\_\_

If you are currently on probation or parole, you must request your probation/parole officer to send a letter describing your current probation/parole requirements and your compliance with supervision.

5. List all felonies, misdemeanors, or other violations of state or federal law for which you have been arrested and which are pending. Submit a copy of the police report/criminal complaint for each of the following pending charges.

<u>PENDING CHARGE</u>	<u>DATE OF ARREST</u>	<u>LOCATION OF ARREST (city/state)</u>
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Comments you wish to make regarding your convictions or pending charges. Attach another sheet if necessary.


## AFFIDAVIT OF APPLICANT

I state that I am the person referred to in this document and that all the information which I provided above is true in every respect. I understand that false or forged statements made in this document in connection with my application for a credential, or failing to provide relevant information, may be grounds for denial of the application, revocation of the credential granted to me, or criminal prosecution. This document must be signed before a notary public.

\_\_\_\_\_  
Signature

State of \_\_\_\_\_ County of \_\_\_\_\_

Signed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_ by \_\_\_\_\_  
(applicant's name)

\_\_\_\_\_  
Signature of Notary Public

My commission (is permanent) \_\_\_\_\_ expires \_\_\_\_\_.

**SEAL**

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## VERIFICATION OF CREDENTIAL

Complete only if you are credentialed in a state other than Wisconsin

### MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING AND SOCIAL WORK EXAMINING BOARD

Please check credential type: ☐ Social Worker ☐ Marriage and Family Therapy Training Cert.  
☐ Social Worker Training Certificate ☐ Professional Counselor  
☐ Marriage and Family Therapist ☐ Professional Counselor Training Certificate

The top portion of this form (numbers 1, 2, 3, 4, 5, and 6) must be completed by the applicant before forwarding to the jurisdiction where previously credentialed.

1. Name

2. Previous Name(s)

3. Address (number, street, city, state, zip code)

4. Date of Birth (month, day, year)

5. Credential Number

6. Date Credential Issued

I authorize the requested information to be furnished to the Wisconsin Marriage and Family Therapy, Professional Counseling, and Social Work Examining Board.

Signature

Date

**APPLICANT: DO NOT WRITE BELOW THIS LINE – To be completed by a state other than Wisconsin**

The lower portion of this form, beginning with number 7, must be completed by the state where you are credentialed (certified, registered, licensed) and returned directly to the Marriage and Family Therapy, Professional Counseling, and Social Work Examining Board, at the above address before your application can be considered for certification.

7. Profession Credentialed (Please include level of credential.)

8. Date Originally Credentialed and level of credential

9. Credential was Issued by:

\_\_\_ Examination \_\_\_ Waiver  
\_\_\_ Endorsement/Reciprocity \_\_\_ Grandfathered

10. Credential is:

\_\_\_ Active (Date Expires \_\_\_\_\_)  
\_\_\_ Inactive

11. Has This Credential Ever Been Revoked, Suspended, Surrendered, Restricted, Limited, Placed on Probation?

\_\_\_ Yes \_\_\_ No If yes, explain on reverse side.

12. If The Applicant Was Credentialed by Examination, Which Exam?

13. Name of Education Program Completed

14. Name of School

15. Location of School

16. Year of Graduation

SEAL/STAMP

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

State: \_\_\_\_\_

Date: \_\_\_\_\_

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## PROFESSIONAL COUNSELOR CERTIFICATE OF PROFESSIONAL EDUCATION

### MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING, AND SOCIAL WORK EXAMINING BOARD

**APPLICANT:** Complete the top portion of this form and forward to your professional school. Request the school to return the completed form directly to the **Professional Counselor Section.**

NAME

\_\_\_\_\_  
(LAST) (FIRST) (MIDDLE) (MAIDEN/FORMER)

ADDRESS

\_\_\_\_\_  
(NO. & STREET OR P.O. BOX) (CITY) (STATE) (ZIP)

DATE OF BIRTH

\_\_\_\_\_  
(MONTH) (DAY) (YEAR)

SOCIAL SECURITY #

\_\_\_\_\_  
Voluntary, for use by school to locate your records

**APPLICANT: DO NOT WRITE BELOW THIS LINE**

### **CERTIFYING SCHOOL** – Please complete this section.

\_\_\_\_\_  
NAME OF INSTITUTION

\_\_\_\_\_  
LOCATION OF INSTITUTION (City/State)

\_\_\_\_\_  
DEGREE AWARDED

\_\_\_\_\_  
MAJOR

\_\_\_\_\_  
DATE OF DIPLOMA

\_\_\_\_\_  
NAME OF THE ACCREDITING BODY  
AT THE TIME STUDENT RECEIVED DEGREE

I certify that the above information is true

Signed: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**SCHOOL SEAL/STAMP**

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## PROFESSIONAL COUNSELOR CURRICULUM REQUIREMENTS

### MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING, AND SOCIAL WORK EXAMINING BOARD

NAME: \_\_\_\_\_

#### Curriculum Requirements for Equivalent Graduate Programs

If you are applying for licensure, with a master's degree **equivalency** in Professional Counseling, you must have **42 semester hours or 63 quarter hours of academic credit** in counseling related courses. These must include a minimum of one course of at least three (3) semester hours or four (4) quarter hours academic credit in: Counseling Theory, Supervised Counseling Practicum, and in six (6) of the other eight (8) content areas. The remaining 18 semester hours or 31 quarter hours of academic credit must also be listed under the content areas into which they fit. **(See Section SFC 14.01)**

If you are applying for licensure with a doctoral degree **equivalency**, you must have **48 semester hours or 72 quarter hours of academic credit** in counseling related courses. These must include a minimum of one course of at least three (3) semester hours or four (4) quarter hours academic credit in: Counseling Theory, Supervised Counseling Practicum, and in each of the other eight (8) content areas. The remaining 18 semester hours or 32 quarter hours of academic credit must also be listed under the content areas into which they fit. **(See Section SFC 14.01)**

**A course may not be used to fulfill more than one content area.** *You must attach college catalog course descriptions and request the school which awarded your master's or doctoral degree to submit an official graduate transcript.*

Content Area	Date	Course Code	Course Title	Credit Hrs.
Counseling Theory				
Supervised Counseling Practicum				

#### SIX OF THE FOLLOWING ARE REQUIRED FOR MASTER'S DEGREE EQUIVALENCY ALL EIGHT ARE REQUIRED FOR DOCTORAL DEGREE EQUIVALENCY

Human Growth and Development				
Social and Cultural Foundations				
The Helping Relationship				
Group Dynamics Process & Counseling				
Lifestyle & Career Development				
Appraisal of Individuals				
Research and Evaluation				
Professional Counseling Orientation				

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## EMPLOYER AFFIDAVIT

### SUPERVISED PROFESSIONAL COUNSELING PRACTICE

#### **MARRIAGE AND FAMILY THERAPY, PROFESSIONAL COUNSELING AND SOCIAL WORK EXAMINING BOARD**

This form must be completed by the applicant's employer/prospective employer and must be submitted by the employer/prospective employer directly to the Department of Regulation and Licensing, PO Box 8935, Madison, WI 53708. This form is part of the application for the Professional Counselor Training Certificate. An individual's application is not complete without this form.

The supervisor may not permit a supervisee to engage in any professional counseling practice that the supervisor cannot competently perform. The supervisor shall be legally and ethically responsible for the activities of the professional counselor trainee. Supervisors shall be available or make appropriate provision for emergency consultation and intervention. Supervisors shall be able to interrupt or stop the supervisee from practicing in given cases and to stop the supervised relationship if necessary.

**Supervised practice outcome requirement.** The applicant shall demonstrate competence to his or her practice supervisor in each of the following areas: counseling principles and techniques; case management; client assessment; ethics, and professional and community interaction. The applicant shall also demonstrate competence in at least 3 of the following 7 areas: coordination and supervision of services; individual and group and family, or individual and group or family counseling techniques; assessment planning, administration and interpretation; service delivery systems and referral; counseling; plan development; legal testimony; and consultation (SFC 12.03).

## **AFFIDAVIT**

I attest to the fact that \_\_\_\_\_ is or will be employed full time in a supervised  
(Name of employee)

professional counseling practice. In this position, the above named employee will receive supervision exercised by:

### **(Check supervisor's qualification(s):**

- ☐ An individual licensed as a Professional Counselor, who has received a doctorate degree in Professional Counseling.
- ☐ An individual licensed as a Professional Counselor, who has engaged in the equivalent of 5 years of full-time Professional Counseling.
- ☐ A psychiatrist or psychologist licensed under chapter 455.
- ☐ A person employed by the division of Vocational Rehabilitation as a Civil Service Vocational Rehabilitation Supervisor, level 3, who is licensed as a Professional Counselor or who is engaged in the equivalent of 5 years of full-time Professional Counseling.
- ☐ Another individual, other than any specified above, who is approved in advance by the Professional Counselor section. Please enclose a written request for approval. Your request must state the educational and practice credentials of the supervisor, and the reason you require this individual instead of a marriage and family therapist, psychologist, psychiatrist, or an AAMFT-approved supervisor, as allowed under MPSW 16.05(1)(a), (b), (c), (d).

\_\_\_\_\_  
Signature of Employer

Print Name \_\_\_\_\_

Supervisor's Credential # \_\_\_\_\_

Profession in which credentialed \_\_\_\_\_

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## NOTICES

### **TIME FOR REVIEW AND DETERMINATION OF CREDENTIAL APPLICATIONS**

Generally, a credentialing authority is required to make a determination on an original application for a credential within 60 business days after a completed application is received.<sup>a</sup> An application is completed when all materials necessary to make a determination on the application and all materials requested by the licensing authority have been received.

### **PROCEDURES ON APPLICATION DENIAL**

An applicant who receives a notice of denial may request a hearing to challenge the denial by filing a request with the appropriate board or the department within 45 days after the mailing of the notice of denial. The request must contain the applicant's name and address, the type of license sought, the reasons why a hearing is requested and a description of the mistake the applicant believes was made, if the applicant claims that the denial was based on a mistake of fact or law. Hearing procedures are specified in ch. RL 1 of the Wisconsin Administrative Code. A copy of ch. RL 1 is available at most public libraries, on the Internet through the index at <http://www.legis.state.wi.us/rsb/code/rl/rl.html> and may also be obtained from the department.

### **MAILING ADDRESS AND CHANGE OF ADDRESS**

Credential holders may use a business address as a mailing address for department mail. A change of address must be reported to the department within 30 days.

### **PERSONALLY IDENTIFIABLE INFORMATION: USE AND AVAILABILITY**

Information collected on an application form is required and will be used to determine eligibility for a credential or examination. It is not likely that the department will use information collected by these forms for other purposes.

Credentialing is a public process with a goal of identifying those competent to protect the public. The name, city, and status of credential holders are accessible at the Department's website at <http://www.drl.state.wi.us/> under "Credential Holder Query." Information collected on application and examination forms is available for inspection to the public under Wisconsin laws governing public records.

### **AMERICANS WITH DISABILITIES ACT**

The Department complies with the Americans With Disabilities Act of 1990. The Department will make reasonable modifications to policies, practices and procedures when modifications are necessary to avoid discrimination on the basis of disability and will make reasonable accommodations necessary to provide a qualified individual with a disability with equal access to department programs.

**Communications and examinations:** Individuals who need auxiliary aids for effective communication in programs and services or who wish to request special accommodations for examinations, please call (608) 266-2852 or TTY at (608) 267-2416.

**Complaints:** Procedures for alleging violations of the Americans with Disabilities Act of 1990 may be obtained by calling the Department's ADA Coordinator at (608) 266-8608 or TTY at (608) 267-2416.

#1988 (Rev. 11/19/02) ss. 15.04 (1) (m), 19.35, Stats.

<sup>a</sup> Section RL 4.06 of the Wisconsin Administrative Code

# Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935  
Madison, WI 53708-8935

FAX #: (608) 261-7083  
Phone #: (608) 266-2112

1400 E. Washington Avenue  
Madison, WI 53703  
E-Mail: [web@drl.state.wi.us](mailto:web@drl.state.wi.us)  
Website: <http://www.drl.state.wi.us>

## APPLICATION PACKET ADDENDUM (INTERNET)

### PROFESSIONAL COUNSELOR TRAINING CERTIFICATE

For the application packet that you have just downloaded, there are additional materials needed.

Please complete this form and fax it to the number listed above. Once the form is returned we will mail the additional items to the address you have provided. If you prefer, you can mail this form directly to the Department of Regulation and Licensing, P.O. Box 8935, Madison, WI 53708.

Please indicate on this form if you have downloaded the Wisconsin Statutes and Code Book for this profession. ☐ Yes ☐ No

### PLEASE PRINT OR TYPE

\_\_\_\_\_  
Full Name

\_\_\_\_\_  
Daytime Phone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
PO Box

\_\_\_\_\_  
City, State, Zip

Thank you.

#2612 (4/03)